		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025346

Facility Name: Little Sisters of the Poor

Address: 2325 N. Lakewood (Number) Chicago (City) 60614 (Zip Code)

County: Cook

Telephone Number: (773) 935-9600 **Fax #** (773) 935-9614

IDPA ID Number: 36-2482272 / 001

Date of Initial License for Current Owners: 05/01/80

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mother Margaret Patricia Lennon **Telephone Number:** (773) 935-9600

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mother Margaret Patricia Lennon
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Elizabeth Vaccariello, Vice President
(Firm Name & Address) Varey & Vaccariello CPAs PC, 617 E Golf Road, Suite 107, Arlington Heights, IL 60005
(Telephone) (847) 228-6977 Fax # (847) 228-0317

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	25	Skilled (SNF)	25	9,150	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,666	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	257			257	8
9	SNF/PED					9
10	ICF	23,647	1,277		24,924	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,904	1,277		25,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.53%

D. How many bed-hold days during this year were paid by Public Aid? 3 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 05/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	376,130	43,655	41,830	461,615		461,615		461,615			1
2	Food Purchase		213,548		213,548		213,548	(108,589)	104,959			2
3	Housekeeping	268,368	24,354		292,722		292,722		292,722			3
4	Laundry	103,694	21,694		125,388		125,388	(6,300)	119,088			4
5	Heat and Other Utilities			294,919	294,919		294,919	(101,819)	193,100			5
6	Maintenance	184,280	35,615	197,158	417,053		417,053	(27,973)	389,080			6
7	Other (specify):*			102,054	102,054		102,054		102,054			7
8	**TOTAL General Services**	932,472	338,866	635,961	1,907,299		1,907,299	(244,681)	1,662,618			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,360,145	42,577	160,706	1,563,428		1,563,428		1,563,428			10
10a	Therapy	8,625		4,325	12,950		12,950		12,950			10a
11	Activities	73,078	14,147	89,789	177,014		177,014		177,014			11
12	Social Services	37,499			37,499		37,499		37,499			12
13	Nurse Aide Training											13
14	Program Transportation			3,373	3,373		3,373		3,373			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,479,347	56,724	261,193	1,797,264		1,797,264		1,797,264			16
	C. General Administration											
17	Administrative			18,000	18,000		18,000		18,000			17
18	Directors Fees											18
19	Professional Services			45,487	45,487		45,487		45,487			19
20	Dues, Fees, Subscriptions & Promotions			44,182	44,182		44,182	(31,319)	12,863			20
21	Clerical & General Office Expenses	205,441	11,755	201,410	418,606		418,606	(18,000)	400,606			21
22	Employee Benefits & Payroll Taxes			629,645	629,645		629,645		629,645			22
23	Inservice Training & Education			3,255	3,255		3,255		3,255			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,120	10,120		10,120		10,120			25
26	Insurance-Prop.Liab.Malpractice			42,105	42,105		42,105	(5,419)	36,686			26
27	Other (specify):*											27
28	**TOTAL General Administration**	205,441	11,755	994,204	1,211,400		1,211,400	(54,738)	1,156,662			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,617,260	407,345	1,891,358	4,915,963		4,915,963	(299,419)	4,616,544			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Little Sisters of the Poor #0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			520,525	520,525		520,525	(28,334)	492,191			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			520,525	520,525		520,525	(28,334)	492,191			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,640		8,640		8,640		8,640			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,724	41,724		41,724		41,724			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		8,640	41,724	50,364		50,364		50,364			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,617,260	415,985	2,453,607	5,486,852		5,486,852	(327,753)	5,159,099			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(108,589)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,100)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,300)	4		8
9	Non-Straightline Depreciation	(28,334)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(18,000)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(99,719)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,877)	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(5,419)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(31,319)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A & Page 5B	(23,096)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (327,753)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (327,753)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Little Sisters of the Poor

ID# 0025346

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Line 15 - Non-Care Related Owner's Transactions	$ (23,096)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(23,096)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(108,589)	0	0	0	0	0	0	0	0	0	0	(108,589)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(6,300)	0	0	0	0	0	0	0	0	0	0	(6,300)	4
5	Heat and Other Utilities	(101,819)	0	0	0	0	0	0	0	0	0	0	(101,819)	5
6	Maintenance	(27,973)	0	0	0	0	0	0	0	0	0	0	(27,973)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(244,681)	0	0	0	0	0	0	0	0	0	0	(244,681)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(31,319)	0	0	0	0	0	0	0	0	0	0	(31,319)	20
21	Clerical & General Office Expenses	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(5,419)	0	0	0	0	0	0	0	0	0	0	(5,419)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(54,738)	0	0	0	0	0	0	0	0	0	0	(54,738)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(299,419)	0	0	0	0	0	0	0	0	0	0	(299,419)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Little Sisters of the Poor # 0025346 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(28,334)	0	0	0	0	0	0	0	0	0	0	(28,334)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28,334)	0	0	0	0	0	0	0	0	0	0	(28,334)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(327,753)	0	0	0	0	0	0	0	0	0	0	(327,753)	45

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Little Sisters of the Poor - Chicago		
				Province, Inc.	Palatine, IL	Religious Order
				LSP - St. Joseph's Home for the		
				Elderly	Palatine, IL	Nursing Home

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ -0-			$ -0-	$ * -0-	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ -0-		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ -0-	$ -0-		$ -0-	25

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NONE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Little Sisters of the Poor											6
7	- Chicago Province, Inc.	X		Working Capital	NONE	12/13/04	300,000	300,000	12/13/09	0.0300	-0-	7
8												8
9	TOTAL Facility Related						$ 300,000	$ 300,000			$	9
	B. Non-Facility Related*											
10	NONE											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 300,000	$ 300,000			$ -0-	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** -0- **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Little Sisters of the Poor # 0025346 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	-0-	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	-0-	2
3. Under or (over) accrual (line 2 minus line 1).	$	-0-	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	-0-	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	-0-	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	-0-	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	-0-	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	-0-	8
	2000	-0-	9
	2001	-0-	10
	2002	-0-	11
	2003	-0-	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Little Sisters of the Poor COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0025346

CONTACT PERSON REGARDING THIS REPORT Mother Margaret Patricia Lennon

TELEPHONE (773) 935-9600 FAX #: (773) 935-9614

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 117,137 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

50 APTS. INDEPENDENT LIVING FACILITIES - NOT a separate entity. Facility is NOT run as a business, but is a part of the mission of the Little Sisters of the Poor - taking care of the elderly poor. Expenses for the apartments are NOT included in this cost report.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Existing Structure	195,291	1979	$ 558,496	1
2					2
3	TOTALS	195,291		$ 558,496	3

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1980	1980	$ 7,986,351	$ 229,150	40	$ 199,659	$ (29,491)	$ 4,917,247	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing & Electric Gates, Parking Misc Electric & Landscaping			1981	274,725	7,883	40	6,868	(1,015)	161,505	9
10	Sliding Gates, Misc Electric & Decorating			1982	9,877	283	40	247	(36)	5,558	10
11	Building Renovation			1983	10,031	288	40	251	(37)	5,408	11
12	Land Improvement - Landscaping			1983	3,265		20			3,265	12
13	Construction of Beauty Shop			1984	27,853	799	40	696	(103)	14,279	13
14	Kitchen Tile, Lighting, Ice Cream Parlor, Reception Area, Closets			1985	41,873	1,201	40	1,047	(154)	20,426	14
15	Land Improvement - Covered Walkway, Concrete Patios			1985	72,492	4,159	20	3,626	(533)	70,797	15
16	Land Improvement - Parking Lot Lights, Park Area			1986	12,805	735	20	640	(95)	11,848	16
17	New Garage			1986	40,590	1,165	40	1,015	(150)	18,813	17
18	Chapel Renovation			1988	66,715	1,914	40	1,668	(246)	27,529	18
19	Electric Work for New Garage			1989	7,615	219	40	191	(28)	2,960	19
20	Garage Completion, Repiping Storage Facility			1990	154,974	4,447	40	3,875	(572)	56,205	20
21	Land Improvement - Paving/Resurface Parking Lots			1990	27,860	1,599	20	1,393	(206)	20,207	21
22	Boiler Room Floor Drains			1991	6,413	184	40	160	(24)	2,160	22
23	Land Improvement - New sidewalks			1996	3,050	175	20	152	(23)	1,292	23
24	Senior Center, Physical Therapy & Elevator Renovation			1997	332,952	9,553	40	8,324	(1,229)	62,430	24
25	Walkway Renovation			1997	222,446	6,383	40	5,561	(822)	41,708	25
26	Combining of Rooms and Room Conversions			1997	37,098	1,064	40	927	(137)	6,953	26
27	Senior Center and Physical Therapy			1998	7,258	208	40	182	(26)	1,183	27
28	Kitchen Renovation			1999	711,148	20,404	40	17,779	(2,625)	97,784	28
29	Window Replacements			1999	239,657	6,876	40	5,991	(885)	32,951	29
30	2nd Floor Room Renovations			1999	162,707	4,670	40	4,068	(602)	22,374	30
31	Land Improvement - Brick Paving of Second Courtyard			2000	16,555	950	20	828	(122)	3,726	31
32	Window Replacements			2000	271,260	7,783	40	6,781	(1,002)	30,514	32
33	Auditorium Roof			2000	50,927	1,461	40	1,272	(189)	5,724	33
34	Two New Electric Front Doors			2001	2,645	76	40	66	(10)	231	34
35	Land Improvement - Concrete Walk and Base			2001	2,527	146	20	126	(20)	441	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Front Door Handicap Access	2002	$ 479	$ 14	40	$ 12	$ (2)	$ 30	37
38	Kitchen Main Grease Trap Replacement	2002	10,443	300	40	261	(39)	653	38
39	Roof Replacements	2002	25,966	745	40	649	(96)	1,623	39
40	Land Improvement - Parking Lot Lights, EE Parking Lot	2003	18,123	1,040	20	906	(134)	1,359	40
41									41
42									42
43									43
44	Capital Building Repair - Per P/A Desk Audit	1985	41,413		40	1,035	1,035	20,710	44
45	Capital Building Repair - Per P/A Desk Audit	1986	42,062		20	2,103	2,103	39,975	45
46	Capital Building Repair - Exterior Doors	1995	3,986		10	395	395	3,986	46
47	CBR - Tuckpointing, Repair Work, Sewer & Doors	1998	131,347		20	6,567	6,567	42,686	47
48	Capital Building Repair - Tank Removal	1999	10,761		5	1,077	1,077	10,761	48
49	CBR - Electric Alt, Chiller and Fire System Repair	2000	17,825		5	3,565	3,565	16,042	49
50	CBR - Heat Pump, Door, Flooring, Drapes, Signs and Heater	2001	47,182		5	9,436	9,436	33,026	50
51	CBR - Flooring, Elec, Plumbing, Kitchen Rprs & Seal Coating	2002	33,755		5	6,751	6,751	16,878	51
52	CBR - Auto, Windows, Fl, Boiler, K, SD & Plumb Rprs	2003	28,582		5	5,716	5,716	8,574	52
53	CBR - Various HVAC Repairs and Sidewalk Repairs	2004	20,124		5	2,012	2,012	2,012	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,235,717	$ 315,874		$ 313,878	$ (1,996)	$ 5,843,833	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	95 Dodge Van	1994	$ 27,745	$	$	$	4	$ 27,745	76
77	Care Use	97 Buick 4dr	1996	11,784				4	11,784	77
78	Care Use	01 Ford Taurus	2001	16,957	4,866	4,239	(627)	4	14,837	78
79	Care Use	01 Ford F150 w/Pl & Spdr	2001	26,618	7,637	6,655	(982)	4	23,292	79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,397,023	$ 172,189	$ 150,028	$ (22,161)	10 Years	$ 730,084	71
72	Current Year Purchases	47,724	2,978	2,595	(383)	10 Years	2,595	72
73	Fully Depreciated Assets	723,228				10 Years	723,228	73
74								74
75	TOTALS	$ 2,167,975	$ 175,167	$ 152,623	$ (22,544)		$ 1,455,907	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	03 Toyota Camry	2002	$ 16,884	$ 4,844	$ 4,221	$ (623)	4	$ 10,553	76
77	Care Use	03 Ford Allstar Van	2003	22,915	6,575	5,729	(846)	4	8,593	77
78	Care Use	04 Ford Truck Econoline	2003	19,384	5,562	4,846	(716)	4	7,269	78
79										79
80	TOTALS			$ 142,287	$ 29,484	$ 25,690	$ (3,794)		$ 104,073	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,104,475	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 520,525	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 492,191	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (28,334)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,403,813	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg - Convent Allocation Various	$ 1,603,939	$ 40,653	$ 862,113	86
87	Equip - Convent Allocation Various	320,232	22,544	215,052	87
88	Vehicles - Convent Allocation Var	21,018	3,794	15,372	88
89					89
90					90
91	TOTALS	$ 1,945,189	$ 66,991	$ 1,092,537	91

G. Construction-in-Progress

	Description	Cost	
92	NONE	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

* ALL AIDES EMPLOYED HAVE PREVIOUSLY OBTAINED THE NECESSARY TRAINING

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ -0-	$ -0-	$ -0-	$ -0-
10	SUM OF line 9, col. 1 and 2 (e)	$ -0-			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ -0-

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	-0-

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	39-2	visits				8,640		8,640	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 8,640		$ 8,640	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Little Sisters of the Poor # 0025346 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 283,078	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	561,776		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,687		6
7	Other Prepaid Expenses	2,787		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Donations Receivable	253,836		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,130,164	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	641,000		13
14	Buildings, at Historical Cost	12,462,619		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,651,512		16
17	Accumulated Depreciation (book methods)	(8,301,700)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,453,431	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,583,595	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 119,630	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,830		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 166,460	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	300,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 300,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 466,460	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,117,135	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,583,595	$	48

***(See instructions.)**

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,395,151	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,395,151	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,278,016)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,278,016)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 8,117,135	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,922,426	1
2	Discounts and Allowances for all Levels	(141,877)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,780,549	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	1,407,993	24
25	Interest and Other Investment Income***	2,294	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,410,287	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management Fees (Adjusted Out on Sch V)	18,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,208,836	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,907,299	31
32	Health Care	1,797,264	32
33	General Administration	1,211,400	33
	B. Capital Expense		
34	Ownership	520,525	34
	C. Ancillary Expense		
35	Special Cost Centers	8,640	35
36	Provider Participation Fee	41,724	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,486,852	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,278,016)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,278,016)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,857	17,617	427,239	24.25	3
4	Licensed Practical Nurses	3,740	4,380	104,003	23.74	4
5	Nurse Aides & Orderlies	52,689	61,454	808,531	13.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	542	542	8,625	15.91	8
9	Activity Director	1,860	2,192	32,480	14.82	9
10	Activity Assistants	3,868	4,164	40,598	9.75	10
11	Social Service Workers	1,419	1,552	37,499	24.16	11
12	Dietician					12
13	Food Service Supervisor	1,943	2,174	33,056	15.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,234	36,093	343,074	9.51	15
16	Dishwashers					16
17	Maintenance Workers	8,964	10,445	184,280	17.64	17
18	Housekeepers	22,041	25,918	268,368	10.35	18
19	Laundry	10,028	11,229	103,694	9.23	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,450	14,688	205,441	13.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,513	1,675	20,372	12.16	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,148	194,123	$ 2,617,260 *	$ 13.48	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	125	$ 4,375	1-3	35
36	Medical Director	60	3,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	2,933	10-3	39
40	Physical Therapy Consultant	87	4,325	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Stipend for One				46
47	Sister Acting as Director of				47
48	Nursing at $750 For 12 Months	2,080	9,000	10-3	48
49	TOTAL (lines 35 - 48)	2,450	$ 23,633		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Stipend for Two Sisters Acting as Administrator and	$
Assistant Administrator at $750 For 12 Months Per Sister	18,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 18,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
R. E. Harrington	Unemploy Comp Consult	$ 393
ADP	Payroll Processing	12,533
Varey & Vaccariello CPAs PC	Accounting and Auditing	31,300
Jackson Lewis	Legal (Care Related)	1,261
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,487

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,301
Unemployment Compensation Insurance	12,177
FICA Taxes	200,220
Employee Health Insurance	310,594
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	64,050
Employee Physicals	3,303
TOTAL (agree to Schedule V, line 22, col.8)	$ 629,645

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,253
Health Care Worker Background Check	
(Indicate # of checks performed 10)	200
Public Relations	31,319
Subscriptions	1,856
Licenses and Fees	949
Dues - Life Services Network of IL	3,290
Dues - Buying Service	2,556
Dues - Misc	759
Less: Public Relations Expense	(31,319)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,863

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Painting	02/2001	$ 13,180	3 Yrs	$ 4,027	$ 4,393	$ 4,393	$ 367	$	$	$	$	$
2	Repair Kitchen HVAC	06/2001	1,650	3 Yrs	321	550	550	229					
3	Painting	10/2001	3,764	3 Yrs	314	1,255	1,255	940					
4	Repairs to HVAC Equip	11/2001	1,818	3 Yrs	101	606	606	505					
5	Repair to Heat Pump	10/2002	1,637	3 Yrs		15	546	546	530				
6	Repair to Lobby Heater	01/2003	3,870	3 Yrs			1,290	1,290	1,290				
7	Boiler Repair	03/2003	2,518	3 Yrs			699	839	839	141			
8	Condenser Pump	03/2003	1,438	3 Yrs			399	479	479	81			
9	Repair Water Pump	04/2003	2,529	3 Yrs			632	843	843	211			
10	Repair Exhaust Fans	05/2003	2,192	3 Yrs			487	731	731	243			
11	Repair Backflow Prev	03/2004	2,000	3 Yrs				556	667	667	110		
12	Repair Hot Water Valv	03/2004	2,701	3 Yrs				750	900	900	151		
13	Repair Heat Pump	05/2004	1,946	3 Yrs				432	649	649	216		
14	Repair Heat Pump	08/2004	1,771	3 Yrs				246	590	590	345		
15	Repair Kitchen HVAC	09/2004	2,290	3 Yrs				254	763	763	510		
16	Repair Kitchen HVAC	10/2004	1,499	3 Yrs				125	500	500	374		
17													
18													
19													
20	TOTALS		$ 46,803		$ 4,763	$ 6,819	$ 10,857	$ 9,132	$ 8,781	$ 4,745	$ 1,706	$	$

Facility Name & ID Number Little Sisters of the Poor **#** 0025346 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,185** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,724**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **-0-** Has any meal income been offset against related costs? **No** Indicate the amount. $ **-0-**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **25% for**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Varey & Vaccariello CPAs PC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.